
203. IDENTIFYING INFORMATION AND MISCELLANEOUS STANDARDS

Oral Doses: Enter the total number of oral medications (doses) given on the target date. Include prescription and non-prescription medications. Count any medication given per feeding tube.

Injections: Enter the total number of injections given on the target date. Include subcutaneous and intramuscular injections. If the resident is receiving intravenous medications via intravenous fluids or Heparin lock, count each time the medication is administered.

Other Medications: Enter the total number of medications, other than oral/injections, given on the target date. Example: eye drops, Nitroing ointment, etc. Count the total number of doses/applications, etc.

Prescriptions in Effect

Total prescriptions: Enter the total number of prescription orders in effect on the target date. Included provided as needed (PRN) medications. Do not include over-the-counter medications such as Tylenol, Maalox, etc.

204. NEW RESIDENTS WITHOUT COMPLETED MINIMUM DATA SET EVALUATIONS

204. NEW RESIDENTS WITHOUT COMPLETED MINIMUM DATA SET
EVALUATIONS

Residents who have been in the facility for less than twenty-one (21) days on the target date shall not have to meet the criteria listed under Sections 201.01B, 201.10D, 201.12F, or 201.17H.

However, only those ADL], behavior problems, special treatments, and clinical monitoring which are documented in the medical record shall be scored on the assessment form.

COMMONWEALTH OF KENTUCKY

Cabinet for Health Services

Department for Medicaid Services

DEPARTMENT FOR MEDICAID SERVICES

NURSING FACILITY PAYMENT SYSTEM

PART III

COST PRINCIPLES

TN # 96-10

Supersedes

TN #

90-6
S/B 92-24
dpt 7/3/01

Approved MAY 16 2001

Eff. Date 7-1-96

Department for Medicaid Services
Cost Principles

Nursing Facilities Reimbursement Manual

TABLE OF CONTENTS

Section 300.	Introduction	Page 300.01
Section 310.	Adequate Cost Data	Page 310.01
Section 320.	Apportionment of Allowable Costs	Page 320.01
Section 330.	Cost Reporting	Page 330.01
Section 350.	Basis of Assets	Page 350.01
Section 351.	Depreciation Expense	Page 351.01
Section 352.	Interest Expense	Page 352.01
Section 353.	Facility Lease or Rent Arrangements	Page 353.01
Section 354.	Capital Leases	Page 354.01
Section 355.	Amortization of Organization and Start-Up Costs	Page 355.01
Section 356.	Accelerated Depreciation To Encourage Refinancing	Page 356.01
Section 360.	Bad Debts, Charity, and Courtesy Allowances	Page 360.01
Section 361.	Cost of Educational Activities	Page 361.01
Section 362.	Research Costs	Page 362.01
Section 363.	Grants, Gifts and Income from Endowments	Page 363.01
Section 364.	Value of Services of Nonpaid Workers	Page 364.01
Section 365.	Purchase Discounts and Allowances, and Refunds of Expenses	Page 365.01
Section 366.	Cost to Related Organizations	Page 366.01
Section 367.	Determination of Allowable Cost of Services, Supplies and Equipment	Page 367.01
Section 368.	Cost Related to Patient Care	Page 368.01
Section 369.	Reimbursement for Services of Physicians	Page 369.01

TN # 96-10

Approved MAY 16 2001

Eff. Date 7-1-96

Supersedes

TN # 92-24

Department for Medicaid Services
Cost Principles

Nursing Facilities Reimbursement Manual

TABLE OF CONTENTS

Section 370. Motor Vehicles	Page 370.01
Section 371. Compensation of Owners	Page 371.01
Section 372. Administrators Compensation	Page 372.01
Section 380. Other Costs	Page 380.01
Section 385. Ancillary Cost	Page 385.01
Section 390. Unallowable Costs	Page 390.01

TN # 96-10

Supersedes

TN # 90-6Approved MAY 16 2001Eff. Date 7-1-96

INTRODUCTION

300. INTRODUCTION

- A. The material in this part deals with provider costs that are reimbursable by the Department for Medicaid Services . In general, these costs are reimbursed on the basis of a provider's actual costs, providing these costs are reasonable and related to patient care. These costs are termed allowable costs. That portion of a provider's total allowable costs allocable to services provided to Medicaid Program recipients shall be reimbursable under the Medicaid Program.
- B. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the facility's operating costs include amount not related to patient care, specifically not reimbursable under the Medicaid Program or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts shall not be allowable.

Page 300.01

TN # 96-10

Supersedes

TN # 90-6Approved MAY 16 2001Eff. Date 7-1-96

INTRODUCTION

300. INTRODUCTION

- C. The determination of allowable cost under this part shall be supplemented by the Health Care Financing Administration Health Insurance Manual.
- D. It is not possible to include the treatment of all items in this manual. a provider presents a question concerning the treatment of cost not specifically covered, or desires clarification of information in this manual, the provider may make a request for determination. The request shall include all pertinent data in order to receive a binding response. Upon receipt of the request, the Department for Medicaid Services shall issue a binding response within sixty (60) days.

310. ADEQUATE COST DATA

310. ADEQUATE COST DATA

- A. To receive reimbursement for services provided Medicaid Program recipients, providers shall maintain financial records and statistical data sufficient to allow proper determination of costs payable under the Medicaid Program.

This cost data shall be of sufficient detail to allow verification by qualified auditors using General Accounting Office and American Institute of Certified Public Accountants guidelines.

The cost data shall be based on Generally Accepted Accounting Principles except where they conflict with this manual or Title XVIII reimbursement principles.

Use of the accrual basis of accounting is required. Governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

Under the accrual basis of accounting, revenue is reported in the period in which it is earned regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

310. ADEQUATE COST DATA

310. ADEQUATE COST DATA

To allow comparability, financial and statistical records shall be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

- B. Providers, when requested, shall furnish the Department for Medicaid Services copies of patient service charge schedules and changes as they are put into effect. The Department for Medicaid Services shall evaluate charge schedules to determine the extent to which they may be used for determining Medicaid payment.
- C. Where the provider has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for service costing or valued at \$10,000 or more over a twelve (12)-month period, the contract shall contain a clause giving the Cabinet for Health Services access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access until four (4) years have expired after the services have been furnished.

Page 310.02

310. ADEQUATE COST DATA

310. ADEQUATE COST DATA

- D. If the Department for Medicaid Services determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost, payments to the provider shall be suspended until the Department for Medicaid Services is assured that adequate records are maintained.
- E. A newly participating provider of services shall, upon request, make available to the Department for Medicaid Services for examination its fiscal and other records for the purpose of determining the provider's ongoing recordkeeping capability.
- F. Records shall be retained by the facility for three (3) years from the date the settled-without-audit or the audited cost report is received from the Department for Medicaid Services.

The financial records and statistical data that shall be kept shall include, but shall not be limited to: (1) records and documents relating to facility ownership, organization, and operation; (2) all invoices and purchase orders, (3) all billing forms or charge slips, (4) all agreements pertaining to asset acquisition, lease, sale or other action; (5) documents pertaining to franchise or management arrangements including costs of

Page 310.03

TN # 96-10

Supersedes

TN # 90-6Approved MAY 16 2001Eff. Date 7-1-96

310. ADEQUATE COST DATA

310. ADEQUATE COST DATA

parent or "home office" operations; (6) patient service charge schedules; (7) contracts pertaining to the purchase of goods or services; (8) all accounting books or original entry kept in sufficient detail to show source and reason for all expenditures and payments; (9) all other accounting books; (10) Federal and State income tax returns; (11) Federal withholding and State Unemployment returns; and (12) all financial statements regardless whether prepared by the facility or by an outside firm.

All of these records shall be made available for examination at the facility, or at some other location within the Commonwealth, when requested by the Cabinet for Health Services. Reasonable time shall be given to out-of-state home offices to make the records available within the Commonwealth.

320. APPORTIONMENT OF ALLOWABLE COST

320. APPORTIONMENT OF ALLOWABLE COST

- A. Consistent with prevailing practices where third party organizations pay for health care on a cost basis, reimbursement under the Medicaid Program involves a determination of (1) each provider's allowable costs of producing services, and (2) an apportionment of these costs between the Medicaid Program and other payors.

Cost apportionment is the process of recasting the data derived from the accounts ordinarily kept by a provider to identify costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

The objective of this apportionment is to ensure, to the extent reasonably possible, that the Medicaid Program's share of a provider's total allowable costs is equal to the Medicaid Program's share of the provider's total services, subject to Medicaid Program limitations on payments so as not to pay for inefficiencies and to provide a financial incentive for providers to achieve cost efficiencies.

320. APPORTIONMENT OF ALLOWABLE COST

320. APPORTIONMENT OF ALLOWABLE COST

A provider's costs shall be apportioned using the cost apportionment method of the Nursing Facilities Annual Cost Report.

- B. If the provider is unable to use the required cost apportionment methods when first participating in the Medicaid Program, it may apply to the Medicaid Program for permission to use some other acceptable method which would accurately identify costs by departments or centers and appropriately segregate routine and ancillary costs.

330. COST REPORTING

330. COST REPORTING

- A. The Medicaid Program requires each Nursing Facility to submit an annual report of its operations. The report shall be filed for the fiscal year used by the provider unless otherwise approved by the Medicaid Program.
- B. Amended cost reports (to revise cost report information which has been previously submitted by a provider) may be permitted or required as determined by the Medicaid Program.
- C. The cost report shall be due within sixty (60) days after the provider's fiscal year ends.
- D. Hospital-based and swing bed provider cost reports shall be due ninety (90) days after the provider's fiscal year ends.
- E. Providers may request in writing a thirty (30) day extension. The request shall explain in detail why the extension is necessary. There shall be no automatic extension of time for the filing of the cost report. After the extension period has elapsed, the Medicaid Program shall suspend all payments to the provider until an acceptable cost report is received.

330. COST REPORTING

330. COST REPORTING

- F. Newly participating providers not having a cost report on file containing twelve (12) months of actual data in the fiscal year shall submit a partial year cost report. Upon entry into the Medicaid Program, the provider shall inform the Department of Medicaid Services of the period ending date for the initial cost reporting period.
- G. A provider which voluntarily or involuntarily ceases to participate in the Medicaid Program or experiences a change of ownership shall file a cost report for that period under the Medicaid Program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement. The report shall be due within forty-five (45) days of the effective date of termination of the provider agreement.
- H. If a new owner's fiscal year end is less than six (6) months from the date of the change of ownership, Schedules A, D-5 and E as well as the ancillary portion of Schedule F shall be required to be filed at the end of the fiscal year. The rate paid to the new owner shall be the old owner's rate and shall remain in effect until a rate is again determined for a new universal rate year.

330. COST REPORTING

330. COST REPORTING

- I. If a provider wishes to change its fiscal year, approval shall be secured in advance from the Department for Medicaid Services prior to the start of the fourth quarter of the original reporting period. If a provider has changed its fiscal year and does not have twelve (12) months in its most recent fiscal year, the provider shall file a cost report for its new fiscal year and include twelve (12) months of data, i.e., the provider should use all months included in their new fiscal year plus additional months from the prior fiscal year to construct a twelve (12) month report.

350. BASIS OF ASSETS

350. BASIS OF ASSETS

- A. PRINCIPLE. Unless otherwise stated in this manual or stated in a provision of Health Insurance Manual 15, which is referenced by this manual directly or indirectly, the basis of an asset shall be the purchase price of that asset paid by the current owner.
- B. REVALUATION UPON CHANGES IN OWNERSHIP. If there is a change in ownership, the Medicaid Program shall treat the gain or loss on the sale of an asset in accordance with one (1) of the following methods (dependent on the date of the transaction) for purposes of determining a purchaser's allowable basis in relation to depreciation and interest costs.
1. For changes of ownership occurring prior to July 18, 1984, or if an enforceable agreement for a change of ownership was entered into prior to July 18, 1984, the following methodology applies:
- a. The actual gain on the sale of the facility shall be determined. Gain shall be defined as any amount in excess of the seller's depreciated basis at the time of the sale as computed under the Medicaid Program policies. The value of

Page 350.01

350. BASIS OF ASSETS

350. BASIS OF ASSETS

Goodwill included in the purchase price shall not be considered part of the gain for purposes of determining the purchaser's cost basis.

- b. Two-thirds ($\frac{2}{3}$) of one (1) percent of the gain for each month of ownership since the date of acquisition of the facility by the seller shall be added to the seller's depreciated basis to determine the purchaser's allowable basis.

This method recognizes a graduated proportion of the gain on the sale of a facility which shall be added to the seller's depreciated basis for computation of the purchaser's allowable basis. This allows full consideration of the gain by the end of twelve and one-half ($12\frac{1}{2}$) years.

2. For changes of ownership occurring on or after July 18, 1984, the allowable basis for depreciation for the purchaser shall be the lesser of: 1) the allowable basis of the seller, at the time of the purchase by the seller, less any depreciation

350. BASIS OF ASSETS

350. BASIS OF ASSETS

allowed to the seller in prior periods; plus the cost of any improvement made by seller, less the depreciation allowed to the seller on those improvements, at the time of closing, or 2) the actual purchase price.

3. a. For change in ownership occurring on or after October 1, 1985, the Department for Medicaid Services shall allow an increase in the valuation of capital assets.
- b. The allowable increase, as measured from the date of acquisition by the seller to the date of change of ownership, shall not be more than the lesser of the following:

350. BASIS OF ASSETS

350. BASIS OF ASSETS

- (1) One-half (1/2) of the percentage increase (as measured over the same period of time, or if necessary, as extrapolated retrospectively by the Secretary, United States Department of Health and Human Services) in the Dodge Construction System Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year; or
- (2) One-half (1/2) of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average).

350. BASIS OF ASSETS

350. BASIS OF ASSETS

- c. Documentation regarding the change of ownership shall be filed with the Division of Licensing and Regulations, Office of Inspector General, with the Department for Medicaid Services, and with either the Interim Office of Health Planning and Certification or the Health Policy Board, as applicable, to ensure the basis of the sale. The increase in valuation of capital assets shall be allowed only if the Department for Medicaid Services concludes, based on documentation presented, that a bona fide arms length commercial transaction, meeting applicable state and federal laws and regulations, has occurred. The increase in valuation shall not be allowed if the change of ownership is between related parties. The increase in valuation shall not be allowed based on a lease being transferred from one (1) individual, agency, organization, or other entity to another.

Page 350.05

TN # 96-10

Supersedes

TN # 94-22Approved MAY 16 2001Eff. Date 7-1-96

350. BASIS OF ASSETS

- d. The increase in valuation shall be based on data in the cost report (annualized as necessary) if available; if a change of ownership has occurred but is not reflected in the cost report used to set the facility rate, the facility may submit a rate adjustment request. A rate adjustment request from a facility shall be accompanied by a Schedule J.
- e. The new useful life of the facility established by the Department for Medicaid Services at the time the increase in valuation of the asset due to a change in ownership is recognized shall begin, for historical cost purposes, at the effective date of the change of ownership.

350. BASIS OF ASSETS

- f. This change shall be applicable for facility rates made for periods beginning July 1, 1995 and thereafter. No rate adjustment shall be applicable for services provided prior to July 1, 1995, or for periods preceding the finalization of the transfer of ownership.
- g. The change shall be accomplished as a rate add-on not subject to usual upper limits. The facilities qualifying for the add-on shall be those facilities with a bona fide change of ownership occurring on or after October 1, 1985 and before the beginning of the rate year. For example, the facilities qualifying for the add-on effective July 1, 1995 shall be those facilities with a bona fide change of ownership occurring on or after October 1, 1985 through June 30, 1995. In order to qualify for the add-on for the rate year beginning on July 1, 1995

Page 350.07

TN # 96-10

Supersedes

TN # 94-22Approved MAY 16 2001Eff. Date 7-1-96

350. BASIS OF ASSETS

the change of ownership shall be reported and necessary cost information to effect the change submitted to the Department for Medicaid Services by not later than September 30, 1995. In order to qualify for the add-on for subsequent rate years, the change of ownership and necessary cost information shall be provided to the Department for Medicaid Services by July 31 of the affected rate year.

- h. For purposes of determining the add-on increase, the allowable basis of the asset for both depreciation and interest shall be the lesser of the previous owner's allowable undepreciated base revalued in accordance with the methodology specified in this section (350, subsection B) or the purchase price of the new owner. The add-on amount shall be the difference between the interest and depreciation allowable before revaluation (i.e., the amount in the rate subject to usual upper limits) and the allowable depreciation and interest after revaluation using usual principles.

350. BASIS OF ASSETS

- I. The add-on amount shall not exceed, on an annual basis, \$3,000,000 based on projected expenditures related to Medicaid occupancy as reported in the facilities' prior year Medicaid cost report. If necessary to reduce add-on amounts to remain within the limit, the reduction of depreciation and interest shown as one (1) add-on amount per facility shall be prorated proportionately among the affected facilities (i.e., the percentage reduction shall be applied equally). For example, if the aggregate of the add-on amounts resulted in a projected additional expenditure of \$3,300,000, which is ten (10) percent in excess of the limit, all add-on amounts would be reduced by ten (10) percent in the aggregate.
- C. SPECIAL CIRCUMSTANCES. For the following circumstances the basis of an asset shall be determined in accordance with the specific provisions of Health Insurance Manual 15 which pertains to these circumstances.

Page 350.09

TN # 96-10

Supersedes

TN # NONEApproved MAY 16 2001Eff. Date 7-1-96

Department for Medicaid Services
Cost Principles

Nursing Facilities Reimbursement Manual

350. BASIS OF ASSETS

1. Intergovernmental transfers of assets.
2. Donated assets.
3. Assets partially or fully depreciated prior to entry into the Medicaid Program.

Page 350.10

TN # 96-10

Approved MAY 16 2001

Eff. Date 7-1-96

Supersedes

TN # NONE

351. DEPRECIATION EXPENSE

351. DEPRECIATION EXPENSE

A. PRINCIPLE. An appropriate allowance for depreciation expense on buildings and equipment shall be an allowable expense. The depreciation shall be:

1. Identifiable and in the facility's accounting records
2. Based on the allowable basis as determined under Section 350; and
3. Prorated over the useful life of the asset.

Goodwill and other intangible assets shall not be depreciated.

B. METHOD OF DEPRECIATION

1. Assets shall be depreciated using the straight-line method, unless another method has been authorized for the facility by Medicare; in which case, the facility may elect to utilize the method authorized for purposes.

351. DEPRECIATION EXPENSE

351. DEPRECIATION EXPENSE

C. USEFUL LIVES

1. In selecting a proper useful life, the 1988 Edition of the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" shall be used with respect to assets acquired in 1989 or later years. For assets acquired from 1983 through 1988, the 1983 Edition of the AHA's guidelines shall be used. For assets acquired before 1982, the 1973 Edition of the AHA's "Chart of Accounts for Hospitals" shall be used; or for assets acquired before 1981, guidelines published by the Internal Revenue Service, with the exception of those offered by the Asset Depreciation Range System, shall be used.

352 INTEREST EXPENSE

352 INTEREST EXPENSE

A. PRINCIPAL. Unless otherwise stated in this manual, interest expense shall be an allowable cost if it meets Medicare Principles and it is both necessary and proper in accordance with the provisions of this manual..

B. DEFINITIONS.

1. Interest. Interest is the cost incurred for the use of borrowed funds.

2. Necessary. Necessary requires that interest:

a. Be incurred on a loan made to satisfy a financial need of the provider which is related to patient care. Loans which result in excess funds or investments shall not be considered necessary.

b. Be incurred on a loan made for the following purposes:

a. Represent interest on a long-term debt existing at the time the provider enters the Medicaid Program plus interest

352. INTEREST EXPENSE

352. INTEREST EXPENSE

on any new long-term debt, the proceeds of which are used to purchase fixed assets relating to the provision of the appropriate level of care not to exceed the allowable basis of the assets. If the debt is subject to variable interest rates found in "balloon" type financing, renegotiated interest rates subject to tests of reasonableness should be allowable. The form of indebtedness may include mortgages, bonds, notes, and debentures when the principal is to be repaid over a period in excess of one year.

- (2) Other interest for working capital and operating needs that directly relate to providing patient care is an allowable cost. Working capital interest shall be limited to the interest expense which would have been incurred on two months of Medicaid Receivables. The amount of which this limitation is to be based is computed for cost reporting purposes by determining the monthly average Medicaid payments (both routine and ancillary) for the Cost Reporting period and multiplying

352. INTEREST EXPENSE

352. INTEREST EXPENSE

the amount by two (2). Once the allowable amount of borrowing has been determined, it is multiplied by the provider's average working capital borrowing rate in order to determine the maximum allowable working capital interest.

It should be emphasized that the two month limit is a maximum. Working capital interest shall not be allowable simply because it does not exceed the two month limitation. Working capital interest that meets the two month test shall meet all other tests of necessary and proper in order for it to be considered allowable.

- (3) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds, or have been separated, if necessary. When investment income is derived from combined or pooled funds, only that portion of

352. INTEREST EXPENSE

352. INTEREST EXPENSE

investment income resulting from the facility's assets after segregation shall be considered in the reduction of interest cost. Income from funded depreciation, a provider's qualified pension fund, or a formal deferred compensation plan shall not be used to reduce interest expense so long as these funds are used only for those purposes for which they were created.

3. Proper. Proper requires that interest:
 - a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.
 - b. Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans that meet one of the related party exemptions of 352 C 2.